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"*We are all* so *different that it is just … normal.*" Normalization practices in an academic hospital in the Netherlands

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ABSTRACT

Internationally, academic hospitals are giving increasing attention to diversity management. This paper sheds light on the actual praxis of cultural diversity management by professionals in workplace interactions. An ethnographic study in a Dutch academic hospital showed that normalization practices were obscuring diversity issues and obstructing inclusion of cultural minority professionals. The normalization of professionalism-as-neutral and equality-as-sameness informed the unequal distribution of privilege and disadvantage among professionals and left no room to question this distribution. Majority and minority professionals disciplined themselves and each other in (re)producing an ideal worker norm, essentialized difference and sameness, and explained away the structural hierarchy involved. To create space for cultural diversity in healthcare organizations in the Netherlands and beyond, we need to challenge normalization practices.

1. Introduction

Cultural diversity is increasingly acknowledged as an important issue in academic medicine and healthcare organizations internationally. In the United States, diversity management in organizations became an issue in the late 1980s, and it arrived in northwestern Europe 10–20 years later (Holvino & Kamp, 2009; Zanoni, Janssens, Benschop, & Nkomo, 2010). Programs addressing diversity in organizations are mainly legitimized by two arguments. The first is based on a moral argument of equality and social justice; it is aimed at equal representation of and equal opportunities for professionals. The second is termed the "business-case scenario" because it argues that diversity among professionals enables creativity and competitive advantage (Ahmed, 2007; Cox, 1994; Thomas & Ely, 1996).

In practice, diversity management is generally thought effective or successful when it enables professionals and organizations to better connect with a diverse clientele and society, resulting in improved performance for organizations (Prasad & Mills, 1997; Prasad, Pringle, & Konrad, 2006). As such, diversity management often takes on an instrumental character (Thomas & Ely, 1996) in which "'the other' is invited to the organization, but is only tolerated and accepted in as far as he or she enriches [but does not challenge] the center" (Holvino & Kamp, 2009, p. 399). Thus, diversity management and diversity programs grounded in equality risk being reduced to "fixing the numbers" – that is, solely focusing on minority representation without addressing organizational culture – while those programs grounded in the business argument risk being acceptable only when their efforts produce efficiency and create profit. These rather limited options for diversity programs may be one reason that – in the US context – the programs seem to have limited impact on recruitment, promotion, and retention of cultural minority professionals (Betancourt, Green, & Carrillo, 2002; Janssens & Zanoni, 2014; Nelson et al., 2002; Turner, González, & Wood, 2008).

Critical diversity studies signal the need to move beyond the often instrumental equality perspectives or business perspectives in diversity management (Cox, 1991; Zanoni et al., 2010). They emphasize that, to achieve actual inclusion of diversity, the role of power and the – foundations of – structural inequalities in organizations and diversity management need to be explored (Ghorashi & Sabelis, 2013; Van Laer & Janssens, 2011; Zanoni et al., 2010). In this paper, we take a critical diversity studies approach toward structural factors of diversity in organizations and contend that for structural inclusion of minority professionals, diversity programs and diversity research need to consider and critically review work floor and organizational cultures. In particular, we answer Zanoni et al. (2010) call for an increase in critical empirical research. Little attention has been paid in diversity

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management studies to how – minority – professionals actually experience and deal with diversity in their daily work environment and how cultural majority and minority professionals relate to each other (Ostendorp & Steyaert, 2009; Van Laer & Janssens, 2014; Zanoni & Janssens, 2007). Moreover, how power "works" and how the production and reproduction of norms, privilege, and disadvantage takes place empirically is largely unclear.

To understand the (re)production of norms and privilege/disadvantage in organizations, we investigated the academic healthcare context in the Netherlands. As the combined field of academia, medicine, and healthcare is traditionally highly exclusive, hierarchical, and monocultural (Taylor, 2003), the academic hospital seemed a relevant setting to study practices of normalization and inclusion of diversity. To our knowledge, there are no empirical studies in academic hospitals that study these topics from a critical diversity perspective. Within the Netherlands, cultural minority professionals in academic hospitals are overrepresented in support staff but underrepresented in many nursing teams and especially in medical and executive staff (Groeneveld & Verbeek, 2012). Earlier empirical studies on cultural diversity in this setting indicate that minority professionals, particularly those who are "visibly different," (e.g., not white, wearing a headscarf), have difficulty "fitting in" Leyerzapf & Abma, 2017; Leyerzapf, Abma, Steenwijk, Croiset, & Verdonk, 2015; Leyerzapf, Rifi, Abma, & Verdonk, submitted; Verdonk, Muntinga, Leyerzapf, & Abma, 2015). The lack of diversity in Dutch academic hospitals may be due to two factors: the Dutch culture's self-image as a society of equal opportunities, a tradition of social justice rhetoric combined with the "celebration" of tolerance for diversity (Ahmed, 2007; Essed, 2002; Heres & Benschop, 2010); and, more recently, the occurrence of polarized discourses that openly show racist tendencies (Essed & Hoving, 2014). Ghorashi, Carabain, and Szepietowska (2015) observed a general paradox in Dutch society of an expressed willingness to include diversity but the incapability to do so in practice, which they attribute to deeply rooted assumptions about cultural minorities as "the Other," who are seen as not only different but also not competent enough to meet the profile of the "normal employee." Thus, the Netherlands is an appropriate context for studying the empirical workings of structural factors for inclusion.

Here, we aim to shed light on the daily *praxis* of cultural diversity management by professionals – that is, how they perceive and deal with diversity in interactions at work and how this relates to inclusion and exclusion as well as privilege and disadvantage. By presenting case examples from an ethnographic study in a Dutch academic hospital, we aim to illuminate how workplace inequalities take shape and are enacted. We hope to extend knowledge within critical diversity studies on the workings of implicit power and normalization in relation to the inclusion of diversity. Ultimately, our objective is to stimulate an inclusive and equitable workplace and work practice for all professionals in academic healthcare and other organizational contexts. Before presenting and discussing our findings, we explain in our theoretical framework the concepts of power and normalization, and in our methodology describe how we operationalized 'cultural diversity' and 'minority/majority'.

2. Theoretical framework

Developed in the mid-1990s as a reaction to diversity management's inability to improve the position of minorities (Holvino & Kamp, 2009), critical diversity studies stress the power dynamics and the structural, contextual aspects of shaping diversity and its inclusion in organizations (Zanoni et al., 2010). Critical diversity studies assume that dominant views on power and diversity prevent power issues and social hierarchies from being challenged (Ghorashi & Sabelis, 2013; Van Laer & Janssens, 2011) as difference – and identity – tend to be reified as something definite, all-encompassing, and exclusive (i.e., essentialism; Nkomo & Cox, 1996). From such dominant views organizations are represented as open, a-political zones in which professionals can "move neutrally" (Ahmed, 2007). By adopting a power lens, critical diversity studies have started to approach the topic of diversity in organizations by involving the concept of difference. They critically address the processes through which certain professionals are included on the basis of their perceived fit with and sameness to organizational norms and other, professionals are excluded on the basis of their perceived non-fit and difference (e.g. Ghorashi & Sabelis, 2013; Holvino & Kamp, 2009). Analyzing this "difference-sameness" axis (Holvino & Kamp, 2009) is a way to start deconstructing the social hierarchies and power structures in organizations. As these are clearly dynamic, dialectical processes (Atewologun, Sealy, & Vinnicombe, 2016; Van Laer & Janssens, 2011, 2014), in particular, the processes of (re)production of these hierarchies need to be unraveled.

Janssens and Zanoni (2014), Zanoni et al. (2010), and Holvino and Kamp (2009) challenged diversity management programs/studies, claiming that these helped to reproduce unequal power relations because they often do not question the strategic, rhetorical objectives of diversity management programs and how these reproduce power imbalances and privileges and disadvantages. Indeed, Heres and Benschop (2010) critical analysis of diversity and equality discourses from leading Dutch companies found that the companies' diversity management remained limited in its impact because it was "framed as an issue for those who are 'different,' not those who, under the dominant norm system, are seen as 'normal'" (p. 452) – showing uses of diversity that are likely to add to exclusion processes. Looking at reproduction of inequalities, Boogaard and Roggeband (2010) discussed the paradox that minority professionals within the Dutch police force occasionally challenge inequality due to their attributed social identities, yet simultaneously reproduce inequality as they deploy these same identities as positive in order to empower themselves and preserve individual power. Other critical diversity studies as Van Laer and Janssens on subtle discrimination (2011), hybrid identity (2014) and agency of minority (2017), and Atewologun et al. (2016) on minority professionals' intersectional identity work, similarly put the interplay between structure and agency at the center of their analysis. These studies show how this dynamic requires active balancing and compromising of minority professionals, resulting in spaces for micro-emancipation (Ghorashi & Sabelis, 2013), yet not in structural inclusion.

In this paper, we adopt a discursive understanding of power, that may provide a more constructive way to address power relations in the workplace and the split minority seem to find themselves in, and that is important in view of the objective of critical diversity studies of generating potential for transformation in organizations. Instead of understanding power as domination or hegemonic power in the tradition of e.g. Gramsci (Foldy, 2002), we propose a Foucauldian-inspired perspective to power. From a perspective of power as domination, power in organizations is perceived as identifiable, visible and material in for example occupational hierarchies, as something "in the hands of" leading, "traditional", and majority professionals "at the expense of" minority (Foldy, 2002; Janssens & Zanoni, 2014). Following Foucault, power is however more implicit, omnipresent and "invisible" (Foucault, 1989, 1982; Ghorashi & Sabelis, 2013). In this Foucauldian tradition, we approach power as performative as it is enacted within discursive spaces in social interactions and routine practices. Moreover, power is rooted in and expressed through norms, or more precisely in processes of normalization of these everyday behaviour, linguistic expressions and non-verbal, bodily interactions that are/become internalized and engrained in mind, body, and culture, and are difficult to pinpoint and transform (Foucault, 1982; Ghorashi & Wels, 2009). Discursive power and normalization are inherently dynamic and dialectical as they are both signifiers and signified of social relations between people, namely who fits in and who deviates. When we focus on normalization practices, we see how power and structures of inequality are thus not unilaterally oppressive. They are productive as all people are necessarily part of its enactment, are mutually dependent on each other in the hierarchical production process, and in that sense all "carry

Table 1
Overview of data collection and participant characteristics.

			Ward A	Ward B	Ward C	Other wards	Total
Interviews (formal & informal), n = 62		By H.L.	7	8	14	2	31
		By research interns	2	14	15	–	31
Participant characteristics of (informal) interviews	Gender	Female	6	14	22	1	43
		Male	3	8	7	1	19
	Cultural background	Majority	5	19	21	–	45
		Minority	4	3	8	2	17
	Position	Nursing staff or doctor's assistant	3	2	8	–	13
		Nursing staff executive	4	6	4	–	14
		Administrative, supportive, or paramedic staff	1	8	2	–	11
		Medical specialist/executive	1	6	4	2	13
		Medical specialist-in-training	–	–	6	–	6
		Medical student	–	–	5	–	5
Participant observations (approx. 100 h)		By H.L.	10	15	10	–	35
		By research interns	10	35	20	–	65

responsibility" (Ghorashi & Sabelis, 2013). In order to gain insight on the dynamic, dialectical enactments of power, we focus on the processes of normalization.

With this study, we hope to show how normalization materializes in everyday encounters on hospital wards and with this to uncover and deconstruct enabling mechanisms of exclusion/inclusion (Ghorashi & Sabelis, 2013). Previous studies have pointed towards yet not placed the praxis of normalization at the center of their research and analysis (e.g., Ghorashi & Sabelis, 2013; Van Laer & Janssens, 2011). Van Laer and Janssens (2011) described how processes of normalization, legitimization and naturalization enabled subtle discrimination in the workplace and worked to disempower minority professionals. Within an approach of power as discursive and normalized, however, agency of minority is not restricted to opposing – majority – structure, and empowerment is an inevitable relational process involving relatively privileged as much as disadvantaged professionals (see also Larruina & Ghorashi, 2016). We therefore look at how privilege and disadvantage are, interrelatedly, reproduced. How the reproduction of power dynamics via normalization practices happen, as well as what actually constitutes this praxis of normalization is still largely unclear. Studies (e.g. Ghorashi & Sabelis, 2013; Larruina & Ghorashi, 2016; Van Laer & Janssens, 2011) make use of different, related concepts besides normalization in this context, such as disciplining, internalization, socialization, naturalization, legitimization, institutionalization, routinization, formalization, homogenization, silencing, and it is not clear how these mutually relate. Therefore, we do not predetermine normalization but aim to build an operationalization of its empirical manifestations by analyzing what is considered "normal" rather than what is considered "different"; how "the Self" is positioned versus "the Other"; and what is implicitly included and privileged instead of only on what constitutes "difference" and "the Other" (Essed, 2002).

3. Methodology

3.1. Study design, research team, and research setting

This ethnographic study investigated the diverse lived experiences and narratives of professionals in their daily work environment (Yanow & Schwartz Shea, 2006; Ybema, Yanow, Wels, & Kamsteeg, 2009).

As awareness of identification and positionality is important in this research, we highlight here our own positioning as authors and come back to it in the discussion (Verdonk & Abma, 2013). We are all female. One of us has been trained as a nurse, and three of us work in a medical center and teach in medicine and health sciences. One of us is not white and has a refugee background. The others are white and from the majority Dutch culture – although one has a white non-Dutch father. We are all privileged in that we are highly educated and, as academics, occupy a high socioeconomic position.

Five research interns supported data collection. One was male, and one identified as a minority. Two were medical students, one was a health sciences student, and two were social science students.

The academic hospital where the research was conducted is situated in the highly urbanized, Western part of the Netherlands, and the university is among the most culturally diverse in the country. To protect the privacy of the participants and the wards, we do not give (personal) details about either. We use the term "ward" to indicate the clinical department representing one medical specialty, including its sub-wards, such as admission wards and the outpatient clinic. The term "team" indicates the different professional teams (i.e., nursing, medical, administrative) that operate in these areas.

3.2. Participant selection and recruitment

Participant selection and recruitment was closely related to and influenced by our use of the key terms "cultural diversity," "minority," and "majority." Cultural diversity is commonly used in Dutch parlance and healthcare regarding issues of migration, integration, inclusion, and diversity management. It suggests cultural/ethnic/racial/religious plurality. We took an emic perspective – "from within" – in this study, asking participants to explain what they perceive as (cultural) diversity. Besides the term "cultural diversity," or "diversity" for short, we use the terms "(cultural) minority" and "(cultural) majority," common in diversity research and scientific debates on inclusion and equality (e.g., Essed, 2002; Ghorashi & Sabelis, 2013). Here majority refers to Dutch professionals with dominant Dutch ethnic backgrounds, and minority refers to Dutch professionals with non-Dutch ethnic backgrounds. Choosing these categories above other comparable terms used in the Netherlands (such as "autochthones" and "allochthones") is based on the critical approach of our study. We believe the category of difference is connected not solely to ethnic, cultural, or racial difference but also to the position of power, that is, the level of privilege.

To get a broad spectrum of perspectives, our selection criteria were: diversity in profession (medical, nursing, administrative, paramedic, or support staff); position (executive, management, and so on); cultural/ethnic/racial position (majority and minority); gender; age; religious affiliation; socioeconomic background; and professional seniority (see Table 1 for an overview).

Recruitment took place by direct approach and by snowball sampling. Minority professionals seemed more hesitant or even reluctant to participate in interviews than majority professionals, more often saying they were too busy to participate or not returning researchers' phone calls and emails. This might be due to their not feeling safe enough to tell majority researchers their experiences or to their fearing consequences at work from being critical about work floor interactions, feelings that may have been increased by the fact that recruitment sometimes happened via majority executives. Researchers were

dependent on executives to gain access to the wards and to be able to recruit and collect data; although all general communication about the research to professionals was done on behalf of the researchers, leading professionals forwarded these messages across the ward and this possibly affected professionals' consideration to participate. Overall, there were few minority professionals to recruit.

3.3. Data collection

Based on a literature review, exploratory interviews, and researchers' knowledge, topic lists to structure interviews and participant observations were formulated (Bernard, 2011). Interview topics were as follows: participant demographics; professional motivation, career background, current position; recruitment and promotion (executives only); daily routine; social interaction with colleagues; professional norms and culture; ideas for the future; humor, being critical, positive and negative work experiences; professional role models; perception of/dealing with cultural diversity; reflections on the research. Topics for participant observations were as follows: demographics; purpose, structure, content of activity; interactions between participants and their roles during those interactions; atmosphere; communication styles, humor, silences, (critical) questions raised, language use, use of stereotypes, prejudice; talk of cultural diversity, labeling majority/minority, different/same; parallels/differences with interviews, other observations; research reflections and researcher expectations.

The sequence of interview topics differed in practice. The goal was to generate reflections about the team, ward, or organizational culture; norms/normativity, difference/"the Other," and normality/"the Self." Participants were first asked how they perceived diversity then how they perceived *cultural* diversity, to observe possible parallels and differences in these categorizations and their own identification with them.

In total, 62 interviews, including the exploratory interviews, were conducted (see Table 1). Fifteen were informal and not recorded. Most interviews were conducted individually, though in two cases, two people, and in one case, three people, were interviewed together. Interviews generally lasted 1 hour, ranging from 30 min to 2 h, and usually took place in private rooms on the wards, though some were conducted in one of the hospital cafeteria's. All formal interviews were recorded, with verbal consent; they were transcribed, made into short reports, and sent to participants for member check (Lincoln & Guba, 1985). On-site notes were made and later turned into reports (Bernard, 2011).

Participant observations (approximately 100 h, see Table 1) were essential in gaining participants' trust, openness, and commitment, which enabled relationship building (Burlew, 2003). They also helped us acquire in-depth, contextualized insight into daily interactions and professionals' social identifications and positionings vis à vis colleagues, which are often difficult to put into words. Again, on-site notes were turned into extensive reports. Observations were made during coffee and lunch breaks, team meetings, management consultations, multidisciplinary patient consultations, patient rounds, and educational seminars, and ranged from 30 min to 8 h. On all three wards, researchers also acted as a "shadow observer" (McDonald, 2005), sometimes in uniform, for a half- or full-day shift.

3.4. Data analysis

Data collection and analysis happened in parallel as much as possible and provided insight for new data collection (Lincoln & Guba, 1985). In this cyclical process, participants were asked to reflect on preliminary interpretations. Different, parallel methods of data collection, namely, formal interviews, participant observations, and informal conversations during observations, enabled us to visualize dominant and alternative perspectives and narratives (Abma, 2006; Jackson & Mazzei, 2013).

Analysis was supported by the use of sensitizing concepts (Denzin, 1973). The conducting researcher (first author) read all notes, reports, and transcripts recurrently to thoroughly familiarize herself with the data and stimulate "close reading" (Yanow & Schwartz Shea, 2006). She wrote preliminary interpretations, which were extensively discussed by all researchers and analyzed to incorporate methodological, theoretical, and philosophical expertise into the interpretation process. These interpretations were subsequently brought back into interviews and participant observations to help focus and stimulate deep, critical reflection by participants and researchers. This "plugging in" of empirical data to theoretical knowledge, and vice versa, is described by Jackson and Mazzei (2013) as thinking *with* theory and data, and it prevents simplistic interpretivism as well as letting empirical data "speak for themselves."

An example of how thinking with theory and data worked was our labeling of preliminary data with the term "normalization." Preliminary interpretations indicated that the term "cultural diversity" related primarily to individual uniqueness and thus all professionals, and defended work floor culture and the status quo on the one hand, while on the other hand it related only to minority people in order to explain experiences of exclusion of minority and problems with their recruitment, selection and retention. This appeared to connect with Ahmed (2007, 2015) on the non-performativity of diversity, that is, the strategic, rhetorical uses of the term "diversity" and diversity-related language to "silence" diversity programs as potential incentives for organizational change. This led us to review our data, focusing on particular language use such as "normal" and "different," and pointed us toward processes of normalization. In subsequent interviews and observations, we were alert to these particular uses and meanings of "diversity" and "majority/minority" and arguments for inclusion and exclusion of what is considered normal at work. In this way, normalization – as closely related to performativity of diversity and organizational change – became a sensitizing concept in data collection and analysis.

3.5. Quality criteria and research ethics

Credibility was enhanced by different data collection methods (triangulation), critical discussion, and looking for differences in interpretations and exceptions in the data (Yanow & Schwartz Shea, 2006). Comparing data from interviews (what participants narrated) and participant observations (how participants related in practice) generated insight into the social praxis of the sensitive, politically laden research topics. The first author kept a diary to critically reflect on her own (automatic) assumptions and her role in the research process (Verdonk & Abma, 2013).

Credibility was validated by presenting anonymized (preliminary) findings to an interdepartmental committee within the hospital, which advocates for inclusion of diversity. Formal quality of the research was consented by the Medical Ethical Board of the hospital and the conducting department's science committee.

Data collection continued until data and theoretical saturation was established (Lincoln, 1995). Confidentiality – crucial to all participants – was ensured as much as possible by anonymizing reported data and the research setting. This was especially important due to the difficulty of maintaining anonymity from people familiar with the setting. Privacy was central in handling, transporting, and storing data (Lincoln, 1995).

4. Findings

Below we describe participants' perceptions of and experiences with cultural diversity issues in the workplace.

4.1. Diversity as being only about the Other

When reflecting on the meaning of diversity at work, both cultural

majority and cultural minority participants initially talked only about patients. Majority professionals told of minority patients who did not want to shake hands with professionals, did not want to be treated by a professional of the opposite sex, or did not speak Dutch well, causing "longer-than-necessary consultations" and delay. They also described patients bringing or being visited by too many family members, and patients and their families expecting too much from hospital staff and medicine in general when facing serious illness. A female minority nurse told of recurrent situations in which patients did not want to be washed by her because she wears a headscarf and of how they commented on her assumed identity:

> I just get that every day … patients […] [t]hey assume I'm Moroccan [because of my] appearance – head scarf and… I am dark-skinned […] And when they hear me talk, it's like 'Hey, an accent, your talk is not really Moroccan …' [laughs] And then it starts! 'Hey! You're not Moroccan are you?! […] But your pronunciation is different' … You know?! This way we always come to the topic of my head scarf, to the Islam.

All minority participants reported these types of recurrent experiences that they themselves or minority colleagues had had, where – often majority – patients refused their help because of their headscarf or where these patients expressed disrespectful comments or questions about their minority background.

Whereas minority professionals mentioned *majority* patients when asked to reflect on diversity issues at work, majority professionals mostly referenced *minority* patients. A majority nurse recounted:

> [S]uch hypes like, shouldn't we now start translating all our patient letters into Turkish or Moroccan, and should we now learn that language or not […] I'm a nurse, I am male […] so, uh, I can care for a Moroccan or Turkish female, but, eh, not if it involves the bare skin. So how am I supposed to [do my work]?

A female, majority administrator told of a situation in which a "foreign" man in the company of four women fully veiled in black came to register. She recounted how she was struck by this and thought "these must be his wives." Immediately, she laughed and added that this was a "silly thought, of course." This situation to her was a clear example of "diversity in the workplace." However, it was the only example she could think of, and she emphasized that cultural diversity was "not really an issue."

As mentioned, all participants initially considered diversity as a relevant topic at work only in relation to patients. Even the minority professionals who described difficult encounters with majority patients did not indicate this was something the organization should address. They presented it as a problem of individual patients; it was a hassle but it did not really affect them:

> You will always have them, these kinds of patients … [they can] just be rude … That's just how it is you know.

In general, diversity issues involving patients were associated with difficult, uncomfortable situations, or even "difficult patients" (e.g., not shaking hands), that were seen as obstructing and disrupting normal (clinical) interactions and taking up (too) much time. Hence, diversity was generally perceived as problematic. Furthermore, diversity was primarily interpreted as cultural diversity, which in the Netherlands also encompasses ethnic, racial, and religious diversity, but not, for example, diversity in sexual orientation, gender, or educational background. These narratives indicated an Othering process whereby diversity became about cultural Others (patients) instead of the normal Self (professionals). Thus, the role of diversity in professionals' conduct, attitudes and wellbeing and diversity as a (potential) issue among professionals themselves seemed obscured.

4.2. Diversity essentialized as either nice or problematic and not quite normal

Eventually, participants related issues of cultural diversity to professionals and the work floor. It was almost exclusively presented as "nice" or "fun" and useful. Examples involving food were mentioned by both majority and minority participants, such as festive lunches or the "multicultural" snacks or sweets colleagues brought to celebrate their birthdays. All participants, majority and minority alike, used such examples to show how diversity is "normal". However, they always added expressions as "yet no problem at all", "yet very much valued", "you know", and "*gewoon*" and "*hoor*", Dutch words difficult to translate, used to normalize an argument. Also, most participants stressed how useful and valuable it is "to have diversity in the team" for working in a plural society. A majority participant said:

> It's good to have colleagues who speak another language, you know, know another culture, to help out with patients with diverse backgrounds.

Majority participants emphasized the convenience of "having culturally diverse colleagues" who would work on Christmas, allowing majority participants to take that holiday off. Again, they dominantly referred to minority colleagues, not mentioning colleagues from Christian or non-urban backgrounds, for example. Minority participants had the same argumentation; they stressed the "importance" and "usefulness" of their own and others' minority backgrounds for enabling the work practice to deliver "culturally diverse care." One minority participant said:

> I actually view my background as an asset to the team, you know … that's my contribution to the work, that I can help them [majority colleagues] with those patients.

Diversity in the context of professionals was approached in a rather instrumental way. Furthermore, it was put forth as something uncomplicated, natural, and not really an issue (i.e., not worth discussing or studying). "Explain to me please *why* you want to study diversity" [emphasis added], said one of the several executives and medical specialists who implicitly or explicitly made their skepticism known to the researcher. This constituted a sort of obscuring and explaining away of diversity issues as well, because the narrative of diversity as a nonissue was upheld and stressed even in situations that appeared to be experienced as complicated and difficult.

Several majority specialists, for example, spoke about a female specialist-in-training who wore long clothes and dark-colored veils. They had pressed her to change her veils in order to "not scare the patients." Dark veils "simply did not fit" the work context, they said. They gave this example to illustrate that diversity "is not an issue in our team," since the specialist-in-training, as one of them stressed, "just did this [without making trouble]," and another added that "that is really the only thing we had here [concerning diversity of professionals]. In fact, however, with this story, they implicitly narrated diversity as problematic, as did the statement they all made that diversity "is no problem." This view was supported by the majority specialists' description of the only minority specialist in their team, saying that "he has a funny name and accent but, otherwise, you do not notice anything about him."

Similarly, minority professionals seemed to explain away the difficulties they experienced at work as they presented cultural diversity among the professionals as unproblematic. Most minority professionals told us that their religion or their wearing a headscarf, having an accent, not drinking alcohol, or not joining team outings "is just accepted," "okay," or "tolerated." Some stressed that, when they had worked on other wards, they had felt excluded and experienced discriminatory remarks from colleagues. Only a few minority participants mentioned that, when they or minority colleagues had addressed the conduct of majority professionals or patients that they had experienced

as stigmatizing them because of their cultural background, they felt they were not taken seriously by majority and sometimes also by minority colleagues. One minority recounted:

> Uh, ... then they just said it was of course not intended as such and that I probably heard it wrong or also [that] I must have misunderstood ... and [they] laughed and said I shouldn't make it so serious.

Several majority participants mentioned that minority professionals sometimes "complain" about disrespectful conduct but that they thought this claim was often "biased" and it was "not clever to deal with it that way." Overall, both majority and minority participants indicated that cultural diversity was not commonly discussed among colleagues. Majority participants said, "No, it's not something we think about really, it's not important … this is just normal here," or "We don't think it's a problem." A minority participant said, "I don't need to think about it because it's just accepted here."

However, the way in which diversity was presented and the words that were used – normal, just, okay, no problem – indicated that the statements obscured an underlying perspective in which the existence of cultural diversity was in fact a potential problem. Furthermore, it suggested that cultural diversity among the professionals resulted from minority professionals being not normal, with their backgrounds, identities, appearances, traditions, and behaviors seen as different and deviant from the norm. The stories of several minority professionals (doctor's assistants) in an outpatient clinic, who, as an exception, were very outspoken, supported this view. They spoke about the majority specialists(-in-training) they worked with and who were often disrespectful to them. One doctor's assistant said:

> Then they yell at you like that, just really yell at you, in the hallway, in front of all the patients […] they don't do that to the [mostly majority] nurses ... they only do that to us.

Several observed situations portrayed the perception of diversity as problematic and as about being different from the majority culture, as well as the active explaining away of this perception by both majority and minority professionals. A majority research intern shadowed a minority support staff member as a form of participant observation. When the minority professional entered the nurses' administrative office and, addressing all, asked for some information, the nurses directed their answers to the majority research intern, who was not wearing a uniform and was standing next to the minority professional. "It seemed as if she was just made out of thin air or something!" the intern said. When asked, the minority professional acknowledged that she had noticed but said she was "used to that" in a rather excusing way. We also observed that – the few – minority professionals who had an executive position were regularly the subject of joking and teasing by – subordinate – majority professionals, relating to their minority identity. For example, these majority participants directed the researcher to their minority colleagues for corroboration that indeed their team was okay with cultural diversity, saying "Oh, ask [XX], he's our foreign guy" or "We have [XX], she's been here for years," and they called their minority colleagues "our diversity" or "our multicultural part."

These examples connect with majority and minority participants speaking of minority professionals as "being culturally diverse," implying a norm from which only minority deviate. Moreover, the examples suggest a process of Othering of minority professionals that is obscured, but apparent in the way "their diversity" was to some extent *tolerated* because nice, fun or useful, yet never quite fitting the norm as it had to be continuously and explicitly defended as being "normal".

4.3. Diversity as individual and professionalism as neutral

When asked to reflect on what they deem important to the work practice, all participants said competency and professionalism. Most minority professionals said that "my diverse background has nothing to do with my work, as only skills, competences, and qualities are important" or "my different background does not matter since they only look at how you work." Majority executives and the few minority executives often concluded their reflections on cultural diversity with saying "But of course, professional quality remains and should remain the leading consideration." In this context, some majority executives brought up "positive discrimination" (i.e., affirmative action) and addressed their fear that attracting more "diverse professionals" would compromise team quality. One said:

> We can't just go and favor culturally diverse professionals … […] we look at their résumé, their experience [...] we have to watch the quality.

Competency was mentioned as the only factor that should determine whether someone is "a good professional," and "the only way you may/are allowed to discriminate between professionals." Overall, competency and professional performance were presented as neutral and objective – and independent from cultural, ethnic/racial, or religious identity. Majority executives even seemed to see professionalism and diversity as being at odds with each other, which relates to the explaining away of diversity among professionals as an issue.

However, when it came to actual appointments, minority and majority professionals –executives and non-executives – pointed to factors other than official criteria for professional competence. They identified as crucial "who fits in with the team" and "experiencing a *click*," as, for example, a majority executive explained:

> There has to be a special connection felt […] if you don't have this personality, you won't fit in the team.

A majority executive recounted how a majority, long-time employee came to her, frustrated, because she had heard that a minority intern was given a position. The executive asked the majority employee if she found the intern's performance lacking. She answered, "No ... she is not incompetent, she is just ... different." Majority executives discussed cases of "equal performance or qualification" – "in that case you choose the one you feel best fits the team." This indicated a consideration of implicit criteria concerning emotional and social aspects beyond or sometimes more important than competency, as well as specific ideas of what good professionals were and what they should look like.

With these norms of professionalism professionals not only explained away but declared diversity among professionals an invalid issue. This happened when majority and minority professionals presented the click or the fit as being based on personality and involving individual difference unrelated to cultural difference or group identity. Minority professionals justified the importance of such "normal differences" of attitude and personal or communicative style at work; as one said:

> You have to have a specific mindset to be able to function in this team … to do this kind of work.

Similarly, a majority executive reacted to a researcher's question about why a certain minority professional was let go: "Oh, but that is personality. You have to fit in of course!" A white, minority executive said that, to "treat every professional equally," he did not look at "irrelevant identity factors like culture or gender but at what personality you have and if it can be an asset to the team." Another majority executive explained why a minority professional had obtained a training position as follows: "...but that was personality. We don't discriminate against people here!" Although this was one of the few times the issue of discrimination was mentioned, most majority executives seemed to want to defend the fairness of their selection practices. In one team, tensions between two "black" professionals and the rest of the team were labeled as "just not functioning properly" and "complicated persons." Thus, these tensions were portrayed as not being related to cultural diversity issues; such tensions did not affect the executive's perception of the team (culture) as open and accepting toward diversity

or the general characterization of diversity as positive and uncomplicated. Even in a ward known in the hospital and by its own members as an exemplary "well-functioning *multicultural* team," professionalism and diversity were disconnected and professionalism was identified as the only thing that mattered as diversity among the team was dealt with by highlighting individual differences other than cultural identity. Like one majority team member said:

> We are all *so* different that it is just … normal!

Thus, the process in which cultural diversity issues were declared invalid in relation to professionals and work floor practice was based on strong ideas about what "a professional" is, agreement that "we all should (want to) be one," and norms regarding who is suited to be a professional or who matches the image, as well as presenting professionalism, competency and quality as neutral and objective criteria. These ideas and norms became normalized by the obscuring, explaining away and silencing of diversity issues, with words such as "just" and "of course" signaling that the status quo was, and should be, taken for granted. Furthermore, these norms were normalized by framing cultural diversity issues among professionals as being about personality and personal, *individual* difference instead of on group identity, and thus independent from social, societal, political – that is, collective – relations, contexts, and structures.

4.4. A normalized social hierarchy: privilege and disadvantage for professionals?

Though the dominant narrative was that cultural diversity was not an issue, participants' accounts and practices indicated an alternative narrative in which cultural diversity was an important aspect in relation to establishing one's professionalism. Most examples, given by both majority and minority professionals, about people not really qualifying as good professionals or as good professional fits for the team were about *minority* professionals. Being a minority seemed – implicitly – identified as not fitting, as being different from or even at odds with the norms of professionalism. Majority professionals generally did not discuss other majority professionals. They seemed to view the norms of professionalism as matching themselves: they described examples of "a non-fit" as "having a foreign/different/strange accent," or plainly said that "people with a minority background often do not display an assertive, open, direct communicative style." Minority professionals were to some extent aware of the need to live up to the norms, to prove they fit in, and of the hierarchical dynamic involved. This was seen, for example, in a minority participant's comment about a fellow minority colleague who wanted to discuss feelings of exclusion or discrimination:

> It's not professional to let yourself be affected by this or let your work of delivering care be affected by it. It's not functional.

This representation of the connection between cultural diversity and professionalism pointed to a – potential – hierarchy between those who fit the norms and those who do not. This hierarchy appeared linked to selective privilege and disadvantage among professionals, as was illustrated by the case of a male, minority physician-in-training. Several majority and minority colleagues mentioned this person as an exemplary "good professional." However, upon obtaining his specialist degree, he organized drinks without serving alcohol, which was met with incomprehension and disappointment by his majority colleagues. As they recounted the situation, it became clear that, by not serving alcohol, he suddenly stopped fitting in and meeting the norms. As one of them said:

> We had expected different from him! … We were surprised and didn't understand this. … He had been so nice all the time and then … this.

The majority professionals not only changed their personal opinion of him but perceived what happened as breaking with a dominant workplace norm (drinks with alcohol), and this discredited his professionalism.

Thus, the workplace was presented by majority and minority participants as neutral in the sense that there were no diversity issues at stake and selection happened on supposedly factual and objective aspects such as competence and individual character. However, it also involved the normalization of majority professionals' physical, social and/or cultural characteristics as constituting the image of the good professional and of minority professionals as differing from those norms, as well as a hierarchical ordering between the two groups. A majority specialist expressed this by using "always" and "of course" and seeing the group as the normal standard to which the minority is the deviant:

> The minority should, of course, always adapt to the group.

The route to successfully qualifying as a professional therefore required identifying and being identified as normal instead of as culturally different. Although minority professionals generally seemed more at risk of not qualifying and being disadvantaged, while majority seemed to qualify more easily and hence were privileged, all participants engaged in these normalization practices – thus upholding the normalization and the potential selective privileging among them.

5. Discussion

Our findings showed how cultural diversity among professionals was narrated as a nonissue, explained away as irrelevant, celebrated as nice and uncomplicated (Ahmed, 2007), or addressed in an instrumental way as being useful only in dealing with difficult or minority patients. Thus, cultural diversity issues such as minority professionals' experiences of exclusion were obscured. Furthermore, cultural diversity issues were declared invalid in a work context by presenting professionalism as unrelated to or even adversely related to and incompatible with cultural identity. Because professionalism, and determining whether someone qualifies as professional, was represented as neutral, objective, rational, context-less, and individual, all differences between professionals became individualized and labeled as variations in personality characteristics. However, strong ideas existed on what constitutes a good professional and who fits the norms. Professionals were thus identified as either normal or different, which created a hierarchy between professionals that was subsequently normalized by the dominant narrative on diversity and professionalism. Thus, cultural diversity was stripped of its structural situatedness and seen as individual, apolitical and independent from social hierarchies and power dynamics. Therefore, normalization of the selective distribution of privilege and disadvantage (i.e., inequity among professionals within the organization) could not be challenged.

We will now look more closely at how normalization practices took place and how they connect with the concept of the ideal worker norm. We discuss the reproduction of the unequal distribution of privilege and disadvantage as well as the process that prevents this distribution from being addressed. Subsequently, we will discuss contextual aspects and the meaning of our findings on normalization for critical diversity theory and future studies.

5.1. Normalization of the ideal worker norm

Our study showed how normalization happened through downplaying cultural diversity by framing it as being about patients only. For the professionals, difference was emphasized as something "we all have or are," that is, cultural diversity was relegated to individual difference. Framing took place via emphasizing the "positive," the nice and uncomplicated aspects of cultural diversity, such as food and festivities, while downplaying the "negative," such as minority professionals' experiences with exclusion, and reframing these as unintentional or misunderstood. Normalization was further enacted through the framing

of professionalism as neutral. Qualification as a good professional was emphasized as being based on objective and rational factors. And differentiation between professionals was presented as being based on personality differences only, while the importance of emotional, social, and cultural connection between professionals was downplayed. Particular language use such as the expressions "of course," "just," "always," and "normal" added to the normalization of these narratives on cultural diversity. These discursive practices represented a dominant narrative that cultural diversity as well as social and political issues of minority inclusion and equality are not at stake in the workplace (see also Ahmed, 2007). Through the enactment of these practices, professionals disciplined themselves and each other into adopting this narrative, hence the narrative became reproduced as well as normalized (Foucault, 1989, 1982).

However, in an alternative narrative, cultural diversity *was* at stake. Cultural diversity was incorporated into professionalism norms regarding who qualified as professional and what constituted normality and difference (e.g., no headscarf vs. a headscarf, respectively). These exclusivist norms played a role in professionals' inclusion. The alternative and dominant narratives both informed each other. The dominant narrative veiled the existence of the alternative narrative in everyday interactions by disarming its logic, countering that we are all the same and emphasizing that cultural diversity is not relevant because professionalism is the only thing that matters. The alternative narrative reinforced the dominant narrative by normalizing its logic, narrating that we are *not* all the same as those that are – seen as – belonging to a minority culture, ethnicity/race, or religion *may* not be able to fit the norms and *may* be less or unprofessional. Together the discursive enactment of these narratives normalized the idea that professionals are all measured against exclusivist norms regarding cultural sameness and difference. This, however, is not an equitable process for majority and minority professionals.

Besides the formal, official criteria on professionalism (the skills and competencies of the dominant narrative), implicit criteria, that is norms on professionalism existed (the "good professional" of the alternative narrative). Adding conceptualizations of the ideal worker in our analysis helped reveal the potential effects of these exclusivist norms in the academic hospital workplace and show how they translated into privilege or disadvantage for professionals. Originating in the field of gender diversity, the norm of the ideal worker – often seen as dominant ethnicity, white, middle/higher social class, fit, heterosexual, young and male –affects careers differently depending on the professionals' socially and personally acknowledged (dis)similarity with this organizational prototype (Ghorashi & Sabelis, 2013; Van den Brink & Benschop, 2011). This ideal seems particularly at play in academic healthcare because of existing tendencies for homogenization, uniformity, and conformity to "fit into the white coat," which are supported by professional claims on neutrality and objectivity and, hence, scientific legitimacy and status (Beagan, 2000; Wear, 1997). Essed (2005) calls this a "cloning process." The existing pressure to fit the norm of a particular kind of professional and the subsequent normalization process are strongly present here and are built on patriarchal, individualistic, principles-based components and a division between the patient as "the Other" and the professional as "the Self" (Bleakley, 2013; Wear & Aultman, 2006).

Indeed, the ideal worker norm in our study seemed to correspond with majority norms in which both majority and minority professionals were engaged. Majority professionals fitted in more easily than their minority colleagues. This agrees with earlier studies in the academic hospital that indicated that minority professionals have to prove themselves against a standard image of a professional that is based on majority norms and risk standing out in a negative way (Leyerzapf & Abma, 2017; Leyerzapf et al., 2015; Verdonk et al., 2015; Leyerzapf et al., 2018; Van den Broek, 2014). Our findings showed how implicit power worked and was dispersed in the norms, culture, narratives, and discursive practices of this setting, thus making it "invisibly" (re) produced by all and difficult to circumvent (Foucault, 1989, 1982).

5.2. Understanding a structural hierarchy between difference and sameness

Normalization was enacted by professionals in different ways, yet all included a reification of difference and sameness. Difference was reified as either a problem concerning – difficult – minority patients or as nice addition (being "multicultural"/minority food or festive traditions) and a useful tool (minority professionals as cultural interpreters) but not primary to the work practice. Sameness was reified in professionalism as the normal, natural Self and equated with all (assumed) majority professionals and the norm worker ideal from which all (assumed) minority professionals deviated. The reification of difference and sameness was based on a simplistic understanding of cultural diversity in which difference was equated with minority workers, or those "culturally diverse," and constituted a static, essentialized cultural Other inherently different from the "normal" Dutch Self (i.e., those qualifying as same). Thus, the reification of difference and sameness springing from the limited understanding of cultural diversity implied not only a dichotomy but also a *hierarchical ordering* of professionals at the workplace (Ghorashi & Sabelis, 2013; Ghorashi et al., 2015; Nkomo & Cox, 1996; Ostendorp & Steyaert, 2009; Zanoni et al., 2010). As this fundamental hierarchy formed the core of being (considered) professional, professionals had little space to criticize it or its consequences and, moreover, worked to normalize and reproduce it.

5.3. Professionalism in academic healthcare and equality-as-sameness

The normalization we saw is supported by international discourses on professionalism in academic medicine that focus on attitudes and behaviors "that can be taught, modeled and evaluated" (Wear & Aultman, 2006, vii), and by discourses in healthcare and society in general that put predominant value on assessment and evaluation (Kipnis, 2008). Internationally, professionalism holds its dominant position because of its conceptual vagueness and legitimized claim to neutrality and objective truth (Van den Brink & Benschop, 2011). In academic healthcare, professionalism constitutes something that can be managed and controlled as neutrally objective, rational, and apolitical, but it has inherent associations with masculinity and individualistic, principles-based thinking that excludes doubt and uncertainty (Beagan, 2000; Bleakley, 2013; Taylor, 2003). However, this professionalism-as-neutral can have very real exclusionary outcomes (Razack, Maguire, Hodges, & Steinert, 2012; Wear & Aultman, 2006).

A further contextual aspect that supported the normalization our study found is the strong norm of equality as constituting cultural sameness in Dutch organizations and Dutch society in general (Essed, 2002; Ghorashi & Sabelis, 2013; Van den Broek, 2014). It stems from the sociopolitical ideal of equality in the Netherlands and a firm belief in Dutch society as democratic and meritocratic (Essed & Hoving, 2014; Van den Broek, 2014). According to Ghorashi (2014), however, difference is tolerated as long as appearance and conduct are "same" and do not challenge the status quo ("*passive* tolerance"). Recent discourses on Dutch superiority over Others – especially non-Western Others and, in particular, assumed Muslims – seem to involve the normalization of racist expressions in society, because the dominant normativity of equality-as-sameness prevents racism from being acknowledged as a real social pattern (Essed & Hoving, 2014; Essed & Trienekens, 2008; Wekker, 2016). Similar mechanisms for normalization practices may be present in other northwestern European countries as well: the professionalism rhetoric is internationally established, and studies in countries such as the UK and Sweden indicate existing ideologies of equality-as-sameness, albeit in the contexts of sexual and gender diversity, respectively (Söderberg & Nyhlén, 2014; Willis, Maegusuku-Hewett, Raithby, ö Miles, 2014).

5.4. Strengths and limitations

Interviews and participant observations provided a dynamic understanding of how issues were enacted in everyday interactions. They enabled critical awareness of the multiple roles of participants in practicing normalization, as well as that of the researchers in "stepping into," questioning and writing about these workplace realities. The research and the researchers' presence on the wards surely affected how participants dealt with diversity. Because our study involved naming invisible interactions and experiences and exploring sensitive topics, such as the – possible – exclusion of employees, confidentiality was an issue throughout the research. This study was limited by privacy concerns (for the participants and the participating wards), which prevented us from providing detailed reflections on context and on – differences in – participants' positionings and (self-) identifications. Furthermore, this study also confronted the researchers with the issue of (their own) whiteness in research (Chadderton, 2012). As a white conducting researcher, it proved difficult to address reports and observations of exclusionary, racist interactions without confirming the hierarchical reification of difference and sameness and thus adding to the normalization taking place, while also trying not to compromise the research.

5.5. Normalization in relation to critical diversity theory and future research

Our findings make clear that future research and projects directed at change toward inclusion of diversity in organizations should focus on the unsettling of normalization as this is the core of the praxis of inclusion/exclusion. Earlier studies have advocated for critically addressing normalization (Ahmed, 2007; DiAngelo, 2011; Fletcher, 1999; Van den Broek, 2014; Wear ö Bickel, 2009; Wear, 1997). Our study showed how normalization is at play and is enacted in situations where there is a disconnect between "talking" diversity and "doing diversity" and that are perceived as unsettling for the organizational status quo. By analyzing the empirical praxis of normalization, our study illustrated how normalization practices constitute an *active* performance of "unseeing" social hierarchies and unequal distribution of privilege and disadvantage and its impact on – minority – professionals at work. They not only entailed a covering up of the power imbalances in professional workplace norms, but also 'deactivated' the – potential – arguments and motivations to address inclusion/exclusion and the need to strive for a more inclusive and equitable workplace culture by declaring these arguments and motivations as invalid. Other critical diversity studies stressed how agency of minority professionals is inherently ambiguous and contentious as they need to "manoeuvre" discursive spaces of power and make "trade-offs" between identity, career and social change (Van Laer ö Janssens, 2011, 2014, 2017), and how majority professionals are crucial in normalizing differences and broadening competency norms to establish equality, especially in larger, hierarchical organizations (Janssens ö Zanoni, 2014) – such as in this case the academic hospital. We share the emphasis these studies put on the burdening experience of exclusion of minority and the need for majority leaders to further organizational change, however, we believe structural practice change requires an integral starting point that focuses on the restraint on agency of *both* minority and majority due to normalization.

With our study, we have shown how majority and minority professionals are all "complicit" in normalization and dealing with inequalities is hence not a matter of redistribution of quantifiable privilege/disadvantage but about a certain quality of social relations. Unsettling normalization, i.e. "re-seeing" inequalities and "re-enforcing" the performativity of diversity management, can only happen when all involved first of all recognize and acknowledge their shared participation and interdependence in power structures, and subsequently practice shared responsibility in the process of change (Medina, 2013). We build on the existing critical diversity theory by researching the specific, namely traditionally hierarchical, context of the academic hospital workplace, and illustrating how here the agentic potential of minority professionals or those relatively disadvantaged is bound with that of majority professionals or those relatively privileged and that they therefore have to work together to challenge social hierarchies and enable transformation. To unsettle normalization, redress power imbalances and make academic healthcare structurally inclusive and equitable, professionals in the hospital need to engage in critical and reflexive "courageous conversations" (Acosta ö Ackerman-Barger, 2017) to rethink professionalism norms, thereby explicitly addressing tacit sources of inequality and exclusion.

To consolidate theory on normalization from a critical, discursive power perspective, we suggest further empirical research in other academic and peripheral hospitals in urban and rural areas within the Netherlands and internationally. Discussions of the parallels and differences in health professionals' narratives and experiences of diversity linked to intersecting identity characteristics other than race, ethnicity, religion, and culture, were beyond the scope of this paper. New research should use an intersectional approach that works from cultural/ethnic/racial diversity but also involves aspects such as gender and social class, and discusses their joint roles in normalization and the unequal distribution of privilege and disadvantage. Research in different geographical, professional, social, and political contexts could investigate how ideologies of sameness, exclusivist discourses, and white privilege are contextually related to normalization (DiAngelo, 2011; Leyerzapf et al., 2015; Verdonk et al., 2015; Wekker, 2016). Critical reflexivity about – normalization of – whiteness in research settings and among the researchers should be part of such studies (Chadderton, 2012).

Conflicts of interest

All authors declare they have no conflicts of interest.

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References

Abma, T. A. (2006). The practice and politics of responsive evaluation. *American Journal of Evaluation, 27*, 31–43.

Acosta, D., & Ackerman-Barger, K. (2017). Breaking the silence: Time to talk about race and racism. *Academic Medicine, 92*, 285–288.

Ahmed, S. (2007). The language of diversity. *Ethnic and Racial Studies, 30*, 235–256.

Ahmed, S. (2015). Brick walls and other hard histories. Difference that makes no difference: the non-performativity of intersectionality and diversity. *Speech Delivered at the International Workshop Frankfurt Research Center for Postcolonial Studies (frcps) in Cooperation with the Women's Network, Cluster of Excellence*.

Atewologun, D., Sealy, R., & Vinnicombe, S. (2016). Revealing intersectional dynamics in organizations: Introducing 'Intersectional Identity Work'. *Gender, Work & Organization, 23*, 223–247.

Beagan, B. L. (2000). Neutralizing differences: Producing neutral doctors for (almost) neutral patients. *Social Science & Medicine, 51*, 1253–1265.

Bernard, H. R. (2011). *Research methods in anthropology: Qualitative and quantitative approaches* (5th ed.). Rowman AltaMira.

Betancourt, J. R., Green, A. R., & Carrillo, J. E. (2002). *Cultural competence in health care: Emerging frameworks and practical approaches, Vol. 576*. New York, NY: Commonwealth Fund, Quality of Care for Underserved Populations.
Bleakley, A. (2013). Gender matters in medical education. *Medical Education, 47*, 59–70.
Boogaard, B., & Roggeband, C. (2010). Paradoxes of intersectionality: Theorizing inequality in the Dutch police force through structure and agency. *Organization, 17*, 53–75.
Burlew, A. K. (2003). Research with ethnic minorities: Conceptual, methodological, analysis issues. In G. Bernal, J. E. Trimble, A. K. Burlew, & F. T. L. Leong (Eds.). *Handbook of racial and ethnic minority psychology* (pp. 179–197). Thousand Oaks, CA: Sage.
Chadderton, C. (2012). Problematising the role of the white researcher in social justice research. *Ethnography and Education, 7*, 363–380.
Cox, T. (1991). The multicultural organization. *Academy of Management Executive, 5*, 34–47.
Cox, T. H. (1994). Tools for organization management and change. In T. H. Cox (Ed.). *Cultural diversity in organizations: Theory, research and practice* (pp. 242–262). San Francisco: Berret-Koehler.
Denzin, N. K. (1973). *The research act: A theoretical introduction to sociological methods.* Transaction publishers.
DiAngelo, R. (2011). White fragility. *International Journal of Critical Pedagogy, 3*, 54–70.
Essed, P. (2002). Cloning cultural homogeneity while talking diversity: Old wines in new bottles in Dutch work organizations? *Transforming Anthropology, 11*, 2–12.
Essed, P. (2005). Gendered preferences in racialized spaces: Cloning the physician. In K. Murji, & J. Solomos (Eds.). *Racialization: Studies in theory and practice* (pp. 227–247). Oxford: Oxford University Press.
Essed, P., & Hoving, I. (2014). Innocence, smug ignorance, resentment: An introduction to Dutch Racism. In P. Essed, & I. Hoving (Eds.). *Dutch Racism* (pp. 9–30). Amsterdam & New York: Rodopi.
Essed, P., & Trienekens, S. (2008). 'Who wants to feel white?' Race, Dutch culture and contested identities. *Ethnic and Racial Studies, 31*, 52–72.
Fletcher, J. (1999). *Disappearing acts: Gender, power, and relational practice at work.* Cambridge, MA: MIT Press.
Foldy, E. G. (2002). 'Managing' diversity: Identity and power in organizations. In I. Aaltio, & A. J. Mills (Eds.). *Gender, identity and the culture of organizations* (pp. 92–112). London: Routledge.
Foucault, M. (1982). The subject and power. *Critical Inquiry, 8*, 777–795.
Foucault, M. (1989). *Discipline, toezicht en straf-de geboorte van de gevangenis.* Groningen: Historische Uitgeverij.
Ghorashi, H. (2014). Racism and "the Ungrateful Other" in the Netherlands. In P. Essed, & I. Hoving (Eds.). *Dutch Racism* (pp. 101–116). Amsterdam & New York: Rodopi.
Ghorashi, H., Carabain, C., & Szepietowska, E. (2015). Paradoxes of (E)quality and good will in managing diversity: A Dutch case in the philanthropic sector. In T. Matejskova, & M. Antonsich (Eds.). *Governing through diversity. Migration societies in post-multiculturalist times* (pp. 83–104). Houndmills: Palgrave.
Ghorashi, H., & Sabelis, I. (2013). Juggling difference and sameness: Rethinking strategies for diversity in organizations. *Scandinavian Journal of Management, 29*, 78–86.
Ghorashi, H., & Wels, H. (2009). Beyond complicity: A plea for engaged ethnography. In S. Ybema, D. Yanow, H. Wels, & F. Kamsteeg (Eds.). *Organizational ethnography: Studying the complexities of everyday organizational life* (pp. 231–253). London: Sage.
Groeneveld, S., & Verbeek, S. (2012). Diversity policies in public and private sector organizations: An empirical comparison of incidence and effectiveness. *Review of Public Personnel Administration, 32*, 353–381.
Heres, L., & Benschop, Y. (2010). Taming diversity: An exploratory study on the travel of a management fashion. *Equality, Diversity and inclusion: An International Journal, 29*, 436–457.
Holvino, E., & Kamp, A. (2009). Diversity management: Are we moving in the right direction? Reflections from both sides of the North Atlantic. *Scandinavian Journal of Management, 25*, 395–403.
Jackson, A. Y., & Mazzei, L. A. (2013). Plugging one text into another: Thinking with theory in qualitative research. *Qualitative Inquiry, 19*, 261–271.
Janssens, M., & Zanoni, P. (2014). Alternative diversity management: Organizational practices fostering ethnic equality at work. *Scandinavian Journal of Management, 30*, 317–331.
Kipnis, A. B. (2008). Audit cultures: Neoliberal governmentality, socialist legacy, or technologies of governing? *American Ethnologist, 35*, 275–289.
Larruina, R., & Ghorashi, H. (2016). The normality and materiality of the dominant discourse: Voluntary work inside a Dutch asylum seeker center. *Journal of Immigrant & Refugee Studies, 14*, 220–237.
Leyerzapf, H., & Abma, T. (2017). Minority medical students' experiences with intercultural competency in medical education. *Medical Education, 51*, 321–330.
Leyerzapf, H., Abma, T. A., Steenwijk, R. R., Croiset, G., & Verdonk, P. (2015). Standing out and moving up: Performance appraisal of cultural minority physicians. *Advances in Health Sciences Education, 20*, 995–1010.
Leyerzapf, H., Rifi, H., Abma, T. and Verdonk, P. (submitted for publication). Veiled Ambitions: Female Muslim medical students and their 'different' experiences in medical education.
Lincoln, Y. S. (1995). Emerging criteria for quality in qualitative and interpretive research. *Qualitative Inquiry, 1*, 275–289.
Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Beverly Hills, CA: Sage.
Medina, J. (2013). *The epistemology of resistance: Gender and racial oppression, epistemic injustice, and resistant imaginations.* New York: Oxford University Press.
McDonald, S. (2005). Studying actions in context: A qualitative shadowing method for organizational research. *Qualitative Research, 5*, 455–473.
Nelson, A. R., Stith, A. Y., & Smedley, B. D. (Eds.). (2002). *Unequal treatment: confronting racial and ethnic disparities in health care (full printed version)*. National Academies Press.
Nkomo, S. M., & Cox, T. (1996). Diverse identities in organizations. In S. R. Clegg, C. Hardy, & W. R. Nord (Eds.). *Handbook of organization studies* (pp. 338–356). London: Sage.
Ostendorp, A., & Steyaert, C. (2009). How different can differences be(come)?: Interpretative repertoires of diversity concepts in Swiss-based organizations. *Scandinavian Journal of Management, 25*, 374–384.
Prasad, P., & Mills, A. J. (1997). From showcase to shadow: Understanding the dilemmas of managing workplace diversity. In P. Prasad, A. J. Mills, M. Elmes, & A. Prasad (Eds.). *Managing the organizational melting pot: Dilemmas of workforce diversity* (pp. 3–27). Thousand Oaks, CA: Sage.
Prasad, P., Pringle, J. K., & Konrad, A. M. (2006). Examining the contours of work place diversity: Concepts, contexts and challenges. In A. M. Konrad, P. Prasad, & J. K. Pringle (Eds.). *Handbook of workplace diversity* (pp. 1–22). London: Sage.
Razack, S., Maguire, M., Hodges, B., & Steinert, Y. (2012). What might we be saying to potential applicants to Medical School? Discourses of excellence, equity, and diversity on the web sites of Canada's 17 Medical Schools. *Academic Medicine, 87*, 1323–1329.
Söderberg, E., & Nyhlén, S. (2014). *Walking beside. Challenging the role of emotions in normalization.* Sundsvall: Mid Sweden University, Forum for Gender Studies, Working Papers 6 2014.
Taylor, J. S. (2003). Confronting "culture" in medicine's "culture of no culture". *Academic Medicine, 78*, 555–559.
Thomas, D. A., & Ely, R. J. (1996). Making differences matter. *Harvard Business Review, 74*, 79–90.
Turner, C. S. V., González, J. C., & Wood, J. L. (2008). Faculty of color in academe: What 20 years of literature tells us. *Journal of Diversity in Higher Education, 1*, 139–168.
Van den Brink, M., & Benschop, Y. (2011). Gender practices in the construction of academic excellence: Sheep with five legs. *Organization, 19*, 507–524.
Van den Broek, L. (2014). Neither with, nor without them—Ethnic diversity on the work floor: How egalitarianism breeds discrimination. In P. Essed, & I. Hoving (Eds.). *Dutch Racism* (pp. 257–272). Amsterdam & New York: Rodopi.
Van Laer, K., & Janssens, M. (2011). Ethnic minority professionals' experiences with subtle discrimination in the workplace. *Human Relations, 64*, 1203–1227.
Van Laer, K., & Janssens, M. (2014). Between the devil and the deep blue sea: Exploring the hybrid identity narratives of ethnic minority professionals. *Scandinavian Journal of Management, 30*, 186–196.
Van Laer, K., & Janssens, M. (2017). Agency of ethnic minority employees: Struggles around identity, career and social change. *Organization, 24*, 198–217.
Verdonk, P., & Abma, T. (2013). Intersectionality and reflexivity in medical education research. *Medical Education, 47*, 754–756.
Verdonk, P., Muntinga, M., Leyerzapf, H., & Abma, T. (2015). Strategisch pendelen tussen gestolde categorieën en fluïde identiteiten. Dynamische verschillen in de zorg begrijpen en onderzoeken vanuit intersectionaliteit. *Tijdschrift voor Genderstudies, 18*, 433–450.
Wear, D. (1997). *Privilege in the medical academy: A feminist examines gender, race, and power.* New York: Teachers College Press.
Wear, D., & Aultman, J. M. (2006). *Professionalism in medicine: Critical perspectives.* New York: Springer.
Wear, D., & Bickel, J. (2009). *Educating for professionalism: Creating a culture of humanism in medical education.* Iowa City, IA: University of Iowa Press.
Wekker, G. (2016). *White innocence: Paradoxes of colonialism and race.* Durham, NC: Duke University Press.
Willis, P., Maegusuku-Hewett, T., Raithby, M., & Miles, P. (2014). Swimming upstream: The provision of inclusive care to older lesbian, gay and bisexual (LGB) adults in residential and nursing environments in Wales. *Ageing & Society, 36*, 282–306.
Yanow, D., & Schwartz Shea, P. (Eds.). (2006). *Interpretation and method: Empirical research methods and the interpretive turn*. New York: M.E. Sharpe.
Ybema, S., Yanow, D., Wels, H., & Kamsteeg, F. (2009). *Organizational ethnography. Studying the complexity of everyday life.* London: Sage.
Zanoni, P., & Janssens, M. (2007). Minority employees engaging with (diversity) management: An analysis of control, agency, and micro-emancipation. *Journal of Management Studies, 44*, 1371–1397.
Zanoni, P., Janssens, M., Benschop, Y., & Nkomo, S. (2010). Guest editorial: Unpacking diversity, grasping inequality: Rethinking difference through critical perspectives. *Organization, 17*, 9–29.